INTRODUCTION

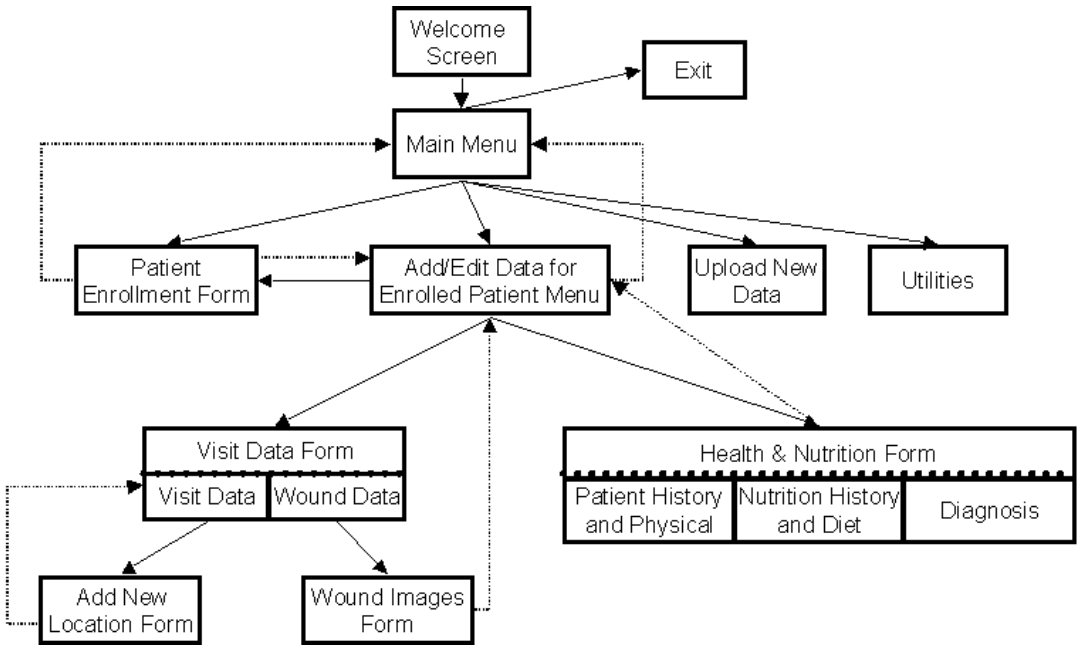
The purpose of this manual is to provide a reference to users of the WATS nurse data entry interface on how to operate this component. This component of WATS is implemented in MicroSoft Access97.

The initial release provided to you at the training session in Ann Arbor (January 20-21) was labeled as Version 1.0. This manual has been revised to reflect changes captured the new version 1.01 release.

Specifically, version 1.01 reflects the following changes:

- Addition of a utility to restore data to tables.
- Improved counter for images – now the correct number is shown as soon as you get into the Wound Images form.

The following diagram shows the layout of the system and navigation between forms and menus:



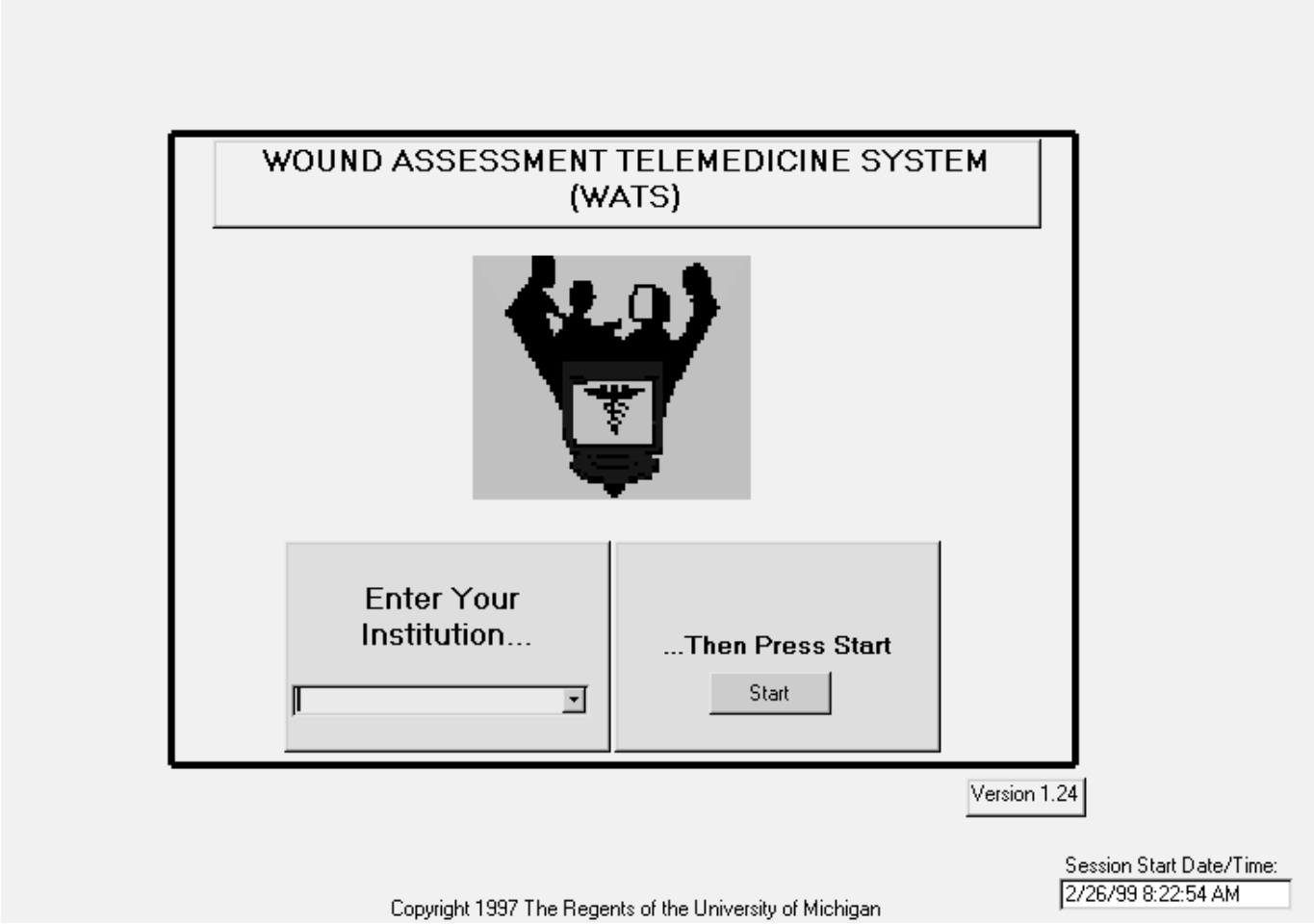
Solid lines show how to proceed from one form/menu to the next. Dashed lines are return paths. The nurse interface component of WATS consists of nine forms or menus.

This manual is divided into ten sections that follow the structure of the WAT nurse data entry interface, as follows:

1. Welcome Screen
2. Main Menu
3. Patient Enrollment Form
4. Add/Edit Data for Enrolled Patient Menu
5. Upload New Data
6. Visit Data Form
7. Add New Location Form
8. Wound Images Form
9. Health & Nutrition Form
10. Utilities

Each of the sections has four parts: 1) General; 2) Description of Elements; 3) Required Elements; and 4) Details. The General part provides an overview of the form and indicates the steps to successful completion of the form. The Description of Elements part provides detail for each of the elements in the form. The Required Fields part lists the elements that are required for you to successfully complete the form. The Details part contains information to help us maintain the system; data elements that are captured in the form are listed along with the respective source tables. Most sections begin with a screenshot of the form being documented.

1 - Welcome Screen



General

This is the first form you will see when starting the WATS nurse data entry interface component. Enter the institution with which you are affiliated. For the pilot, your choices are MI, GA, and a demonstration option. The patients captured and managed by your instance of WATS are determined based on your institution. For example, if you are affiliated with MI, you will have access to all patients enrolled in the Ann Arbor, Michigan site. Click on the start button when you are ready to proceed.

Description of Elements

Institution: A select list is available for you to pick your institution. The pilot study will give you three choices. The demonstration is for use by study administrators who may need to show the system using artificial patient data or data that has been explicitly approved by the patient for general use.

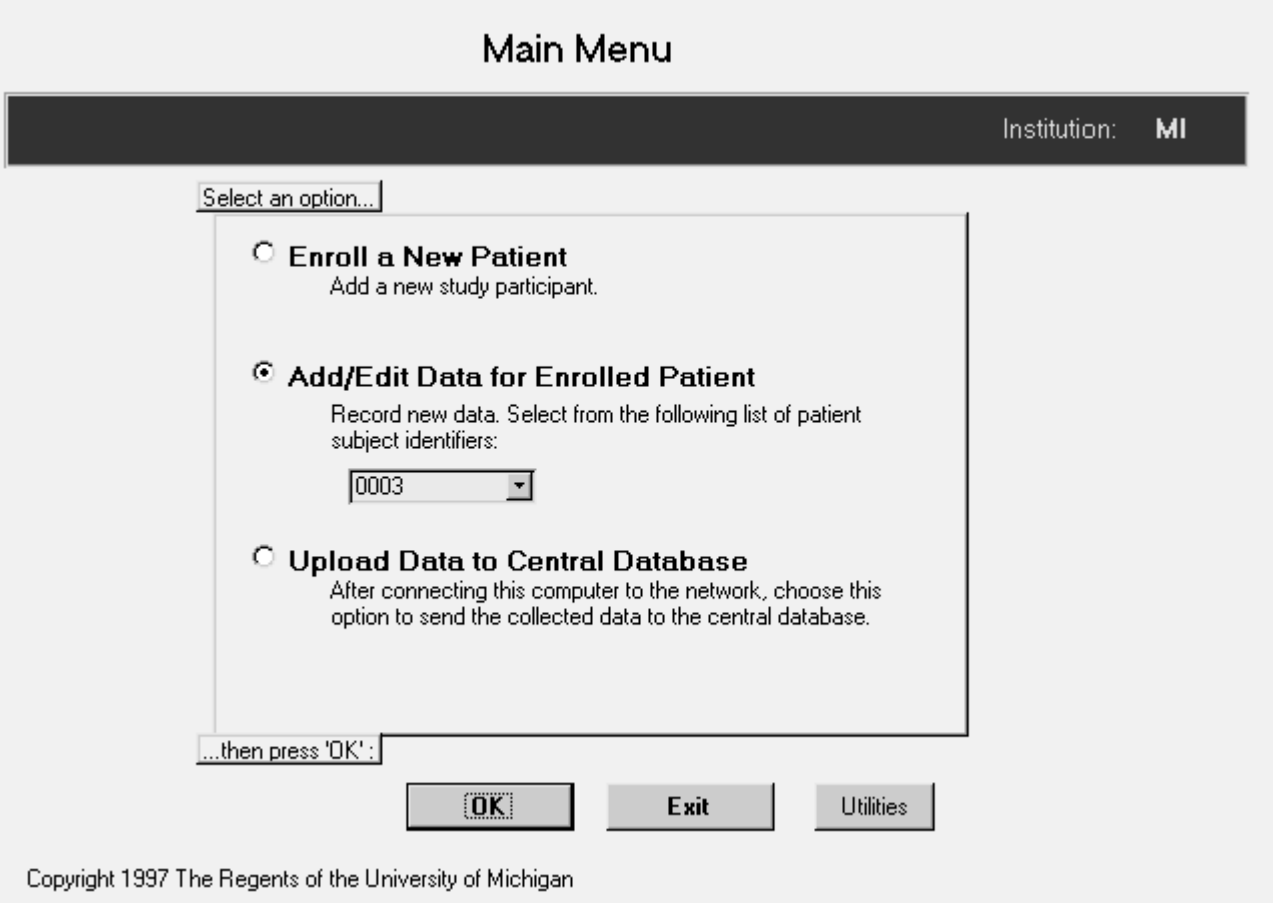
Required Elements

Institution: You must enter a value from the list before clicking START. Otherwise, you will get an error message.

Details

No tables are modified with this form. "institution_id" and "institution_name" from table_institution_list and "username" from table_time_track tables are used to build the picklist.

2 - MAIN MENU



General

The Main Menu presents the three major tasks you can accomplish with this system. Select one of three options by clicking on the corresponding radio button: 1) Enroll a New Patient; 2) Add/Edit Data for Enrolled Patient; or 3) Upload Data to Central Database. Most of your time will likely be spent in the Add/Edit Data for Enrolled Patient option. By default, this option is selected.

Current date and time are captured when you enter this menu. The duration of each of your sessions is being tracked so we can estimate the average time required to do the data entry activities on a per patient basis in the study.

Click OK to proceed or Exit to exit out of the program completely.

Description of Elements

Enroll a New Patient: selection of this task will take you to the Patient Enrollment Form. Select this option to enroll a new patient into the system. All patients enrolled with this option for your institution will show up in the selection box in the next option.

Add/Edit Data for Enrolled Patient: selection of this task will take you to the Add/Edit Data for Enrolled Patient Menu. Select this option if you want to add or modify baseline, visit, or health and nutrition data for an enrolled patient. You must select a subject identifier from the selection box to proceed with this task. Just click on the ▼ to see the full list of identifiers. All identifiers created in the Enroll a New Patient task affiliated with your institution are included in this list. You must select a subject identifier from the selection box to proceed with this option.

Upload Data to Central Database: before you select this option, you must be connected to an appropriate network or other valid connection to the WATS Oracle central database. A message box will show, keeping you apprised of status. Do not perform this task until you are sure patient data have been entered accurately. The date and time of the last upload is shown on the form.

Institution: This element is shown on every screen after you select it from the selection box on the Welcome screen.

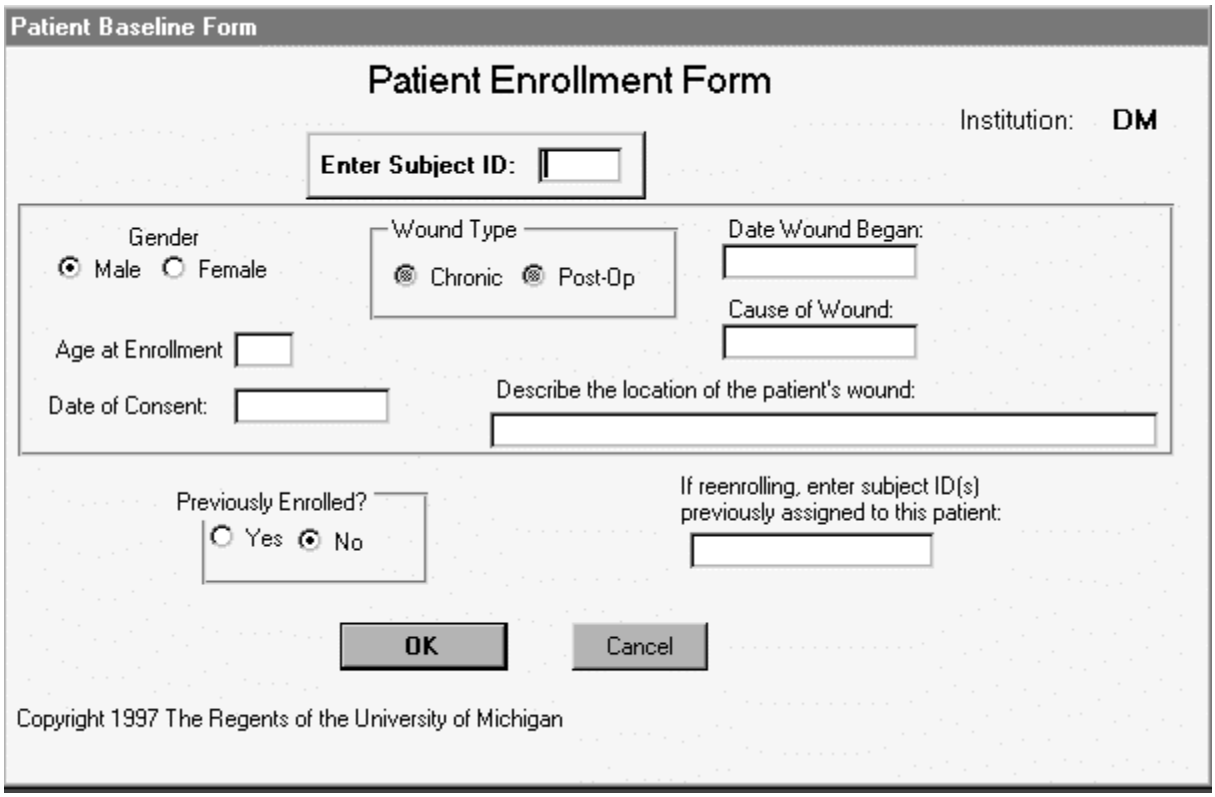
Required Elements

No required elements.

Details

No tables are modified with this form.

3 - PATIENT ENROLLMENT FORM



General

A Patient Enrollment Form must be completed for every patient in the system. Visit , image, nor health and nutrition data can be entered until the patient is enrolled using this form.

Description of Elements

Institution: This element is shown on every screen after you select it from the selection box on the Welcome screen.

Subject ID: Enter this element from the hardcopy master enrollment form for the patient. This element must be four characters with leading zeros, e.g., 0001. It is important this identifier match the Subject ID assigned to this patient for the study. Once you click OK, you will not be able to change this element.

Gender: Click the radio button corresponding to gender. Default is Male.

Age at Enrollment: Enter the age of the patient at time of enrollment. Must be an integer between 0 and 130.

Date of Consent: Enter the date patient signed consent form for the study. Use mm/dd/yyyy format.

Wound Type: Classify the patient's ulcer as Chronic or Post-Op. You will also capture this at each visit. This variable is used to provide general classification for each patient.

Date Wound Began: Enter the date the wound first appeared. Estimate the date based on duration or other information. Enter using mm/dd/yyyy format.

Cause of Wound: Enter a short description of the cause of the wound.

Location of Patient's Wound: Enter a description of location of the wound being followed in the study. E.g., Right ischial pressure sore.

Previous Subject IDs: This field is optional and is an open-text field. If the patient is being reenrolled under a new identifier, enter previous identifiers assigned to this patient. This information will be used by the telemedicine physician to provide more background for the patient, if needed.

Previously Enrolled: Click on the radio button that indicates whether or not the patient has been enrolled previously. The default value is No. If the value is Yes, the Previous Subject IDs should be listed.

Required Elements

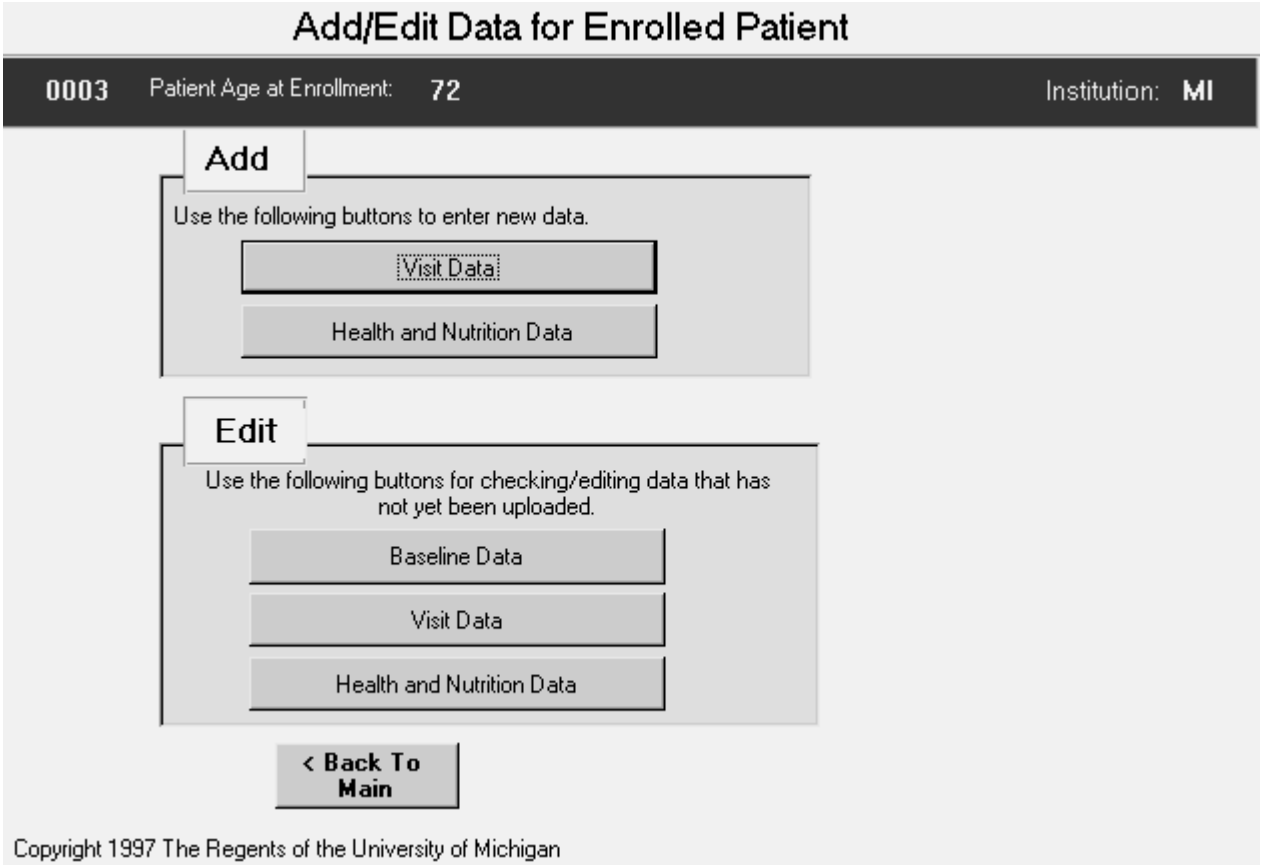
Subject ID	Age at Enrollment	Wound Type
Gender	Date of Consent	

Details

Records in table_patient_baseline and table_wound_baseline are created with this form. A query selecting all elements from both tables is bound to this form where subject ID and institution are equal to values entered by the user. Specifically, the following elements are entered with this form:

Table_patient_baseline	Table_wound_baseline
Subject_id	Subject_id
Institution_id	Institution_id
Gender	Wound_number = 1
Age_at_enrollment	Wound_location
Date_of_consent	Wound-cause
	Date_of_origin
	Wound_type

4 - ADD/EDIT DATA FOR ENROLLED PATIENT MENU



General

This menu provides options related to adding or editing visit, baseline, image, and health and nutrition data for enrolled patients. Two options are available for adding data (visit or health and nutrition data) and three related to editing existing data (baseline, visit, or health and nutrition data).

Description of Elements

Subject ID: (0001 in this example screen). This is the subject ID chosen from the selection box in the Main Menu.

Institution: This element is shown on every screen after you select it from the selection box on the Welcome screen.

Add - Visit Data: Click on this option to enter data for an unrecorded visit for the selected patient using the Patient Visit Data Form. Use the Add-Visit Data option if you need to enter data for an unrecorded visit. This option will provide you with a blank Patient Visit Data Form.

Add – Health and Nutrition Data: Use this option to add unrecorded health and nutrition data for the selected patient. These data may or may not be collected at every visit. We have provided a separate form for you to capture this detail. This option will take you to the Health and Nutrition Data Form, populated with data from the previous health and nutrition evaluation to ease data entry.

Edit – Baseline Data: Use this option to go to the Enroll a Patient form to change or check baseline data you have already entered. You cannot edit baseline data that has already been uploaded to the central database nor can you alter the Subject ID.

Edit – Baseline Data: Use this option if you want to change or check visit data. You cannot edit visit data that has already been uploaded to the central database. This option will take you to the Patient Visit Data Form, populated with data from the most recent visit. You will have the ability to navigate to earlier records that have not been uploaded to the central database.

Edit – Health and Nutrition Data: This option will allow you to change or check entered Health and Nutrition data. You cannot edit health and nutrition data that have already been uploaded to the central database.

Back to Main: Click on this button if you want to go back to the Main Menu. Choose this option if you want to exit the system or enter data for a different patient.

Help: Click on this button to get a description of the system.

Required Elements

No required elements.

Details

No tables are modified with this form.

5 – UPLOAD NEW DATA

General

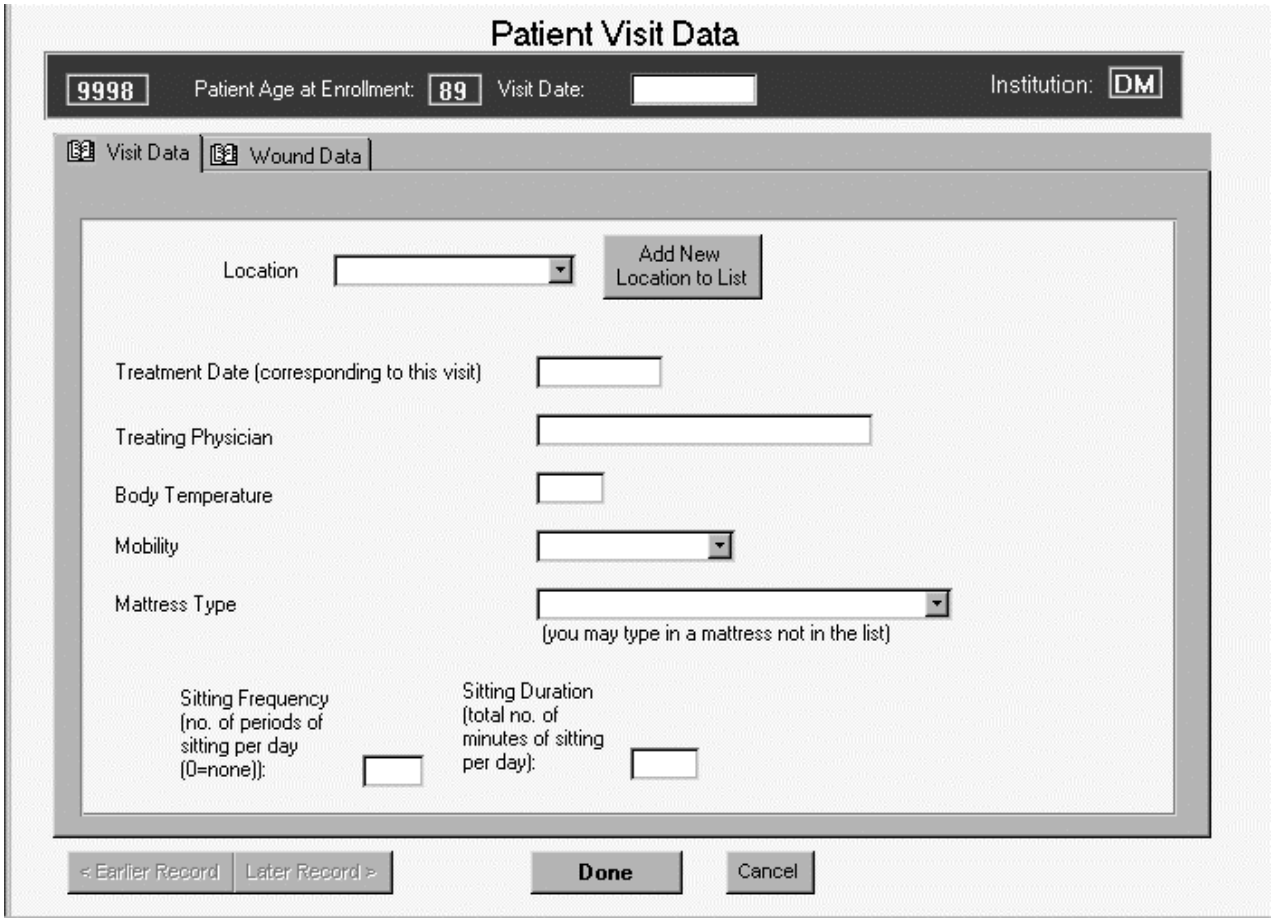
A message will show when you click on the Upload New Data button on the Main Menu, prompting you to ensure you are really ready to upload data. Once data have been uploaded to Oracle, you cannot edit records. The general sequence of actions for each table is as follows when the upload function has begun:

1. The table is searched for whether new records to upload exist.
2. If no records exist or existing records have already been uploaded, a message box will indicate this.
3. If uploadable records exist, the Oracle table master is appended with the new records.
4. Records are purged from the local table in Access.
5. If the table is one of three key tables (table_patient_baseline, table_wound_baseline, or table_patient_health) the local table is repopulated with data from the Oracle master table for the current user's institution.

These steps are repeated for each table.

If you need to repopulate your key data (because of corruption or other mishap to your laptop) you can run the upload routine to rebuild.

6A - PATIENT VISIT DATA FORM – VISIT DATA TAB



General

This form is used to add or edit patient visit data. If you are here to edit existing data, the form will be populated with the most recent visit record. You will have the ability to navigate to earlier records that have not yet been uploaded to the central database. If you are in this form to edit existing visit data, these navigation buttons will be available to you at the bottom of the screen:

This form consists of two “tabs”. One for Visit Data (which shows when you first enter the form and one for Wound Data. This section will document elements related to the visit data tab. To go to the wound data tab, simply click on the Wound Data area. A later section will document the wound data tab.

Description of Elements

Institution: This element is shown on every screen after you select it from the selection box on the Welcome screen.

Subject ID: This element is shown in every screen after you select it from the selection box on the Main Menu.

Age at Enrollment: This element is shown in every screen after you select the patient for which you are adding or modifying data.

Visit Date: If you are editing existing data, this date is populated with the value that already exists. If you are adding a new visit record, the field is left blank by default. Since the visit date is a required field, you must enter in the value reflecting the proper date in mm/dd/yyyy format. Enter the date on which you performed the visit for the purpose of gathering data for the telemedicine physicians.

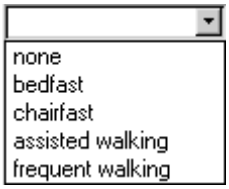
Location: This field captures the location of the patient. You can indicate entities such as ward, home, or nursing home, or more specific locations such as Glacier Hills Nursing Home. If you need to add a new location to the list, click on the Add Location button. The initial version you receive from Ann Arbor will not have a starting list so you must click on the Add Location button to populate the list.

Treatment Date: Enter the treatment date (in mm/dd/yyyy format) that corresponds to this visit. In most cases, this date will be the same as the Visit Date. This date represents the date the patient was seen by a physician in a clinic.

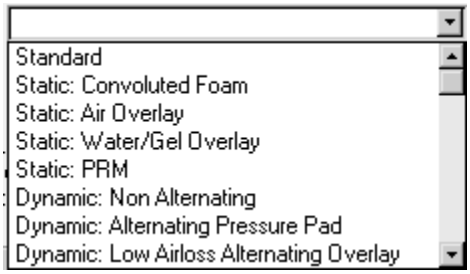
Treating Physician: Enter the name of the treating physician; e.g., Dr. Smith

Body Temperature: Record the body temperature of the patient. Must be a real number between 70.0 and 150.0.

Mobility: Choose from the selection box. The following choices are available:



Mattress Type: Choose from the selection box. You are able to add new types to the list by typing in a new mattress type. The following list is available in the selection box:



Sitting Frequency: Enter the number of sitting times in a day for the patient. Must be an integer.

Sitting Duration: Enter the total sitting time (may be estimated) in a day for the patient.

Required Elements

Visit Date	Body Temperature	Sitting Frequency
Location	Mobility	Sitting Duration
Treating Physician	Mattress Type	

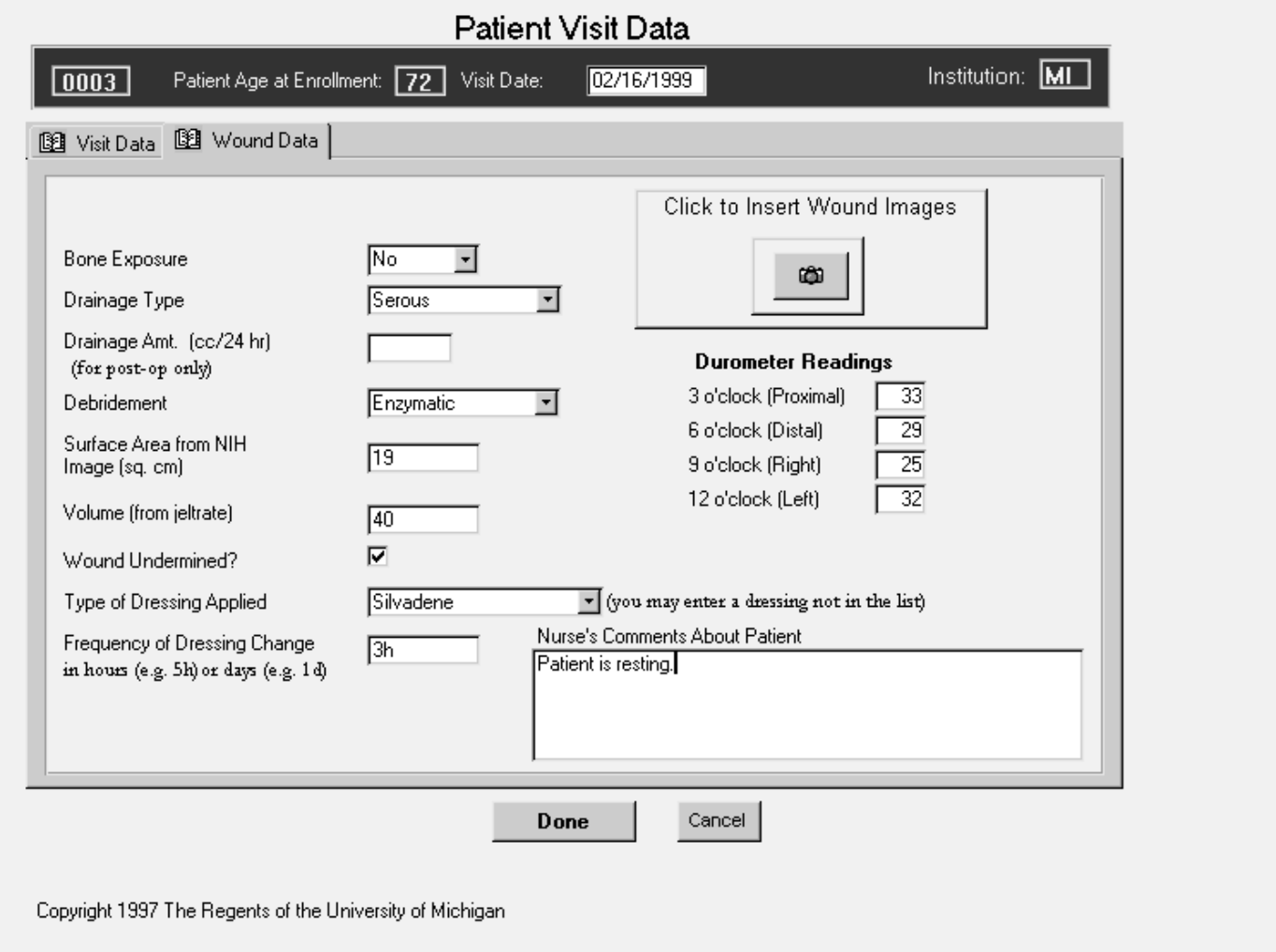
Details

Records in table_patient_visit and table_wound_visit are created or edited with this form. A query selecting all elements from both tables is bound to this form where subject ID, institution, and visit date are equal to values entered by the user. For the Visit Data tab, the following elements are entered:

Table_patient_visit

Subject_id
Institution_id
Date_of_visit
Location_code
mattress
sitting_freq
sitting_interval
treating_physician
date_of_treatment
body_temperature
mobility

6B - PATIENT VISIT DATA FORM – WOUND DATA TAB



General

This form is used to add or edit patient visit data. If you are here to edit existing data, the form will be populated with the most recent visit record. You will have the ability to navigate to earlier records that have not yet been uploaded to the central database. If you are in this form to edit existing visit data, these navigation buttons will be available to you at the bottom of the screen:

This form consists of two "tabs". One for Visit Data (which shows when you first enter the form and one for Wound Data. This section will document elements related to the Wound Data tab. To go to the Visit Data tab, simply click on the Visit Data area. The previous section documented the Visit Data tab.

This tab gives you the option of going to the Wound Images form to enter images for the patient associated with the visit. Click on the  icon to go to the Wound Images Form.

Description of Elements

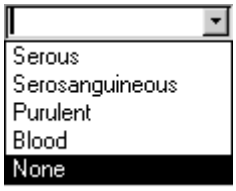
Institution: This element is shown on every screen after you select it from the selection box on the Welcome screen.

Subject ID: This element is shown in every screen after you select it from the selection box on the Main Menu.

Age at Enrollment: This element is shown in every screen after you select the patient for which you are adding or modifying data.

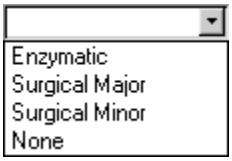
Visit Date: If you are editing existing data, this date is populated with the value that already exists. If you are adding a new visit record, the field is left blank by default. Since the visit date is a required field, you must enter in the value reflecting the proper date in mm/dd/yyyy format. Enter the date on which you performed the visit for the purpose of gathering data for the telemedicine physicians.

Drainage Type: This element will most likely only apply to Post Op patients. Select the appropriate choice from the selection box. The choices available include:



Drainage Amount: This element is activated only for Post Op patients. Enter the drainage amount in cc per 24 hours as an integer.

Debridement: Enter the debridement method applicable from the selection box. Choices available are:

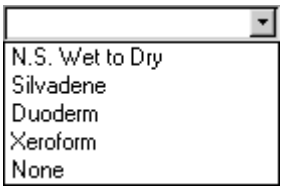


Surface Area: This value is obtained with the NIH Image software. Follow documented protocols to compute surface area. Enter the value here in square inches as an integer.

Volume: This value is obtained from the jeltrate measurement obtained by following the documented protocol. Enter the value in grams here as an integer.

Wound Undermined?: Check the box (by clicking on it) to indicate if the wound is undermined.

Type of Dressing Applied: Choose the dressing applied from the selection box. You can enter another type if it does not appear on the list. The default list will have the following choices:



Frequency of Dressing Change: Enter the frequency of dressing change here. Indicate the units of time with a single letter character after an integer. E.g., 5h for changes every five hours.

Durometer Readings: This form requests up to four durometer readings obtained by following documented protocols. If the patient is Post Op, four elements will appear, translated as readings for Proximal, middle, and distal positions relative to the wound. If the patient is not Post Op, then enter four readings for 3/6/9/12 o'clock positions relative to the wound.

Nurse's Comments About the Patient:: This is an open-text field to enter comments summarizing wound and patient status. Enter items of note, not captured in the system, here.

Required Elements

Visit Date
Bone Exposure
Debridement
Drainage Type
Wound Undermined
Type of Dressing
Frequency of Dressing Change

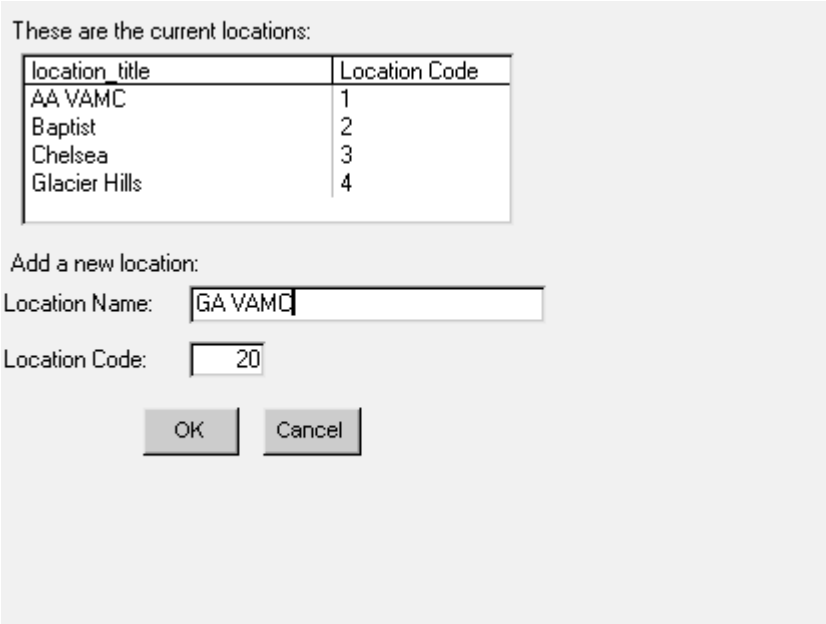
Details

Records in table_patient_visit and table_wound_visit are created or edited with this form. A query selecting all elements from both tables is bound to this form where subject ID, institution, and visit date are equal to values entered by the user. For the Wound Data tab, the following elements are entered:

Table_wound_visit

Subject_id
Institution_id
Visit_date
Wound_number = 1
Bone_exposure
Drainage
Drainage_amount
Debridement_method
Area
Volume
Undermined
Dressing
Dressing_interval
Nurse_comments
Durometer_reading_1
Durometer_reading_2
Durometer_reading_3
Durometer_reading_4

7 - ADD NEW LOCATION FORM



General

The Add New Location form is used to add new locations to the list of choices available in the selection box on the Patient Visit Data Form. A unique identifier is automatically assigned to your entry.

A table is presented to list current locations already available to chose from along with the location code, which is a unique identifier assigned to each entry.

Click OK to save your entry and return to the Visit Data Form or Cancel to return without saving your entry.

Description of Elements

Location Name: This is an open-text field to enter a new Location Title.

Location Code: This code is assigned automatically by the system.

Required Elements

No required elements.

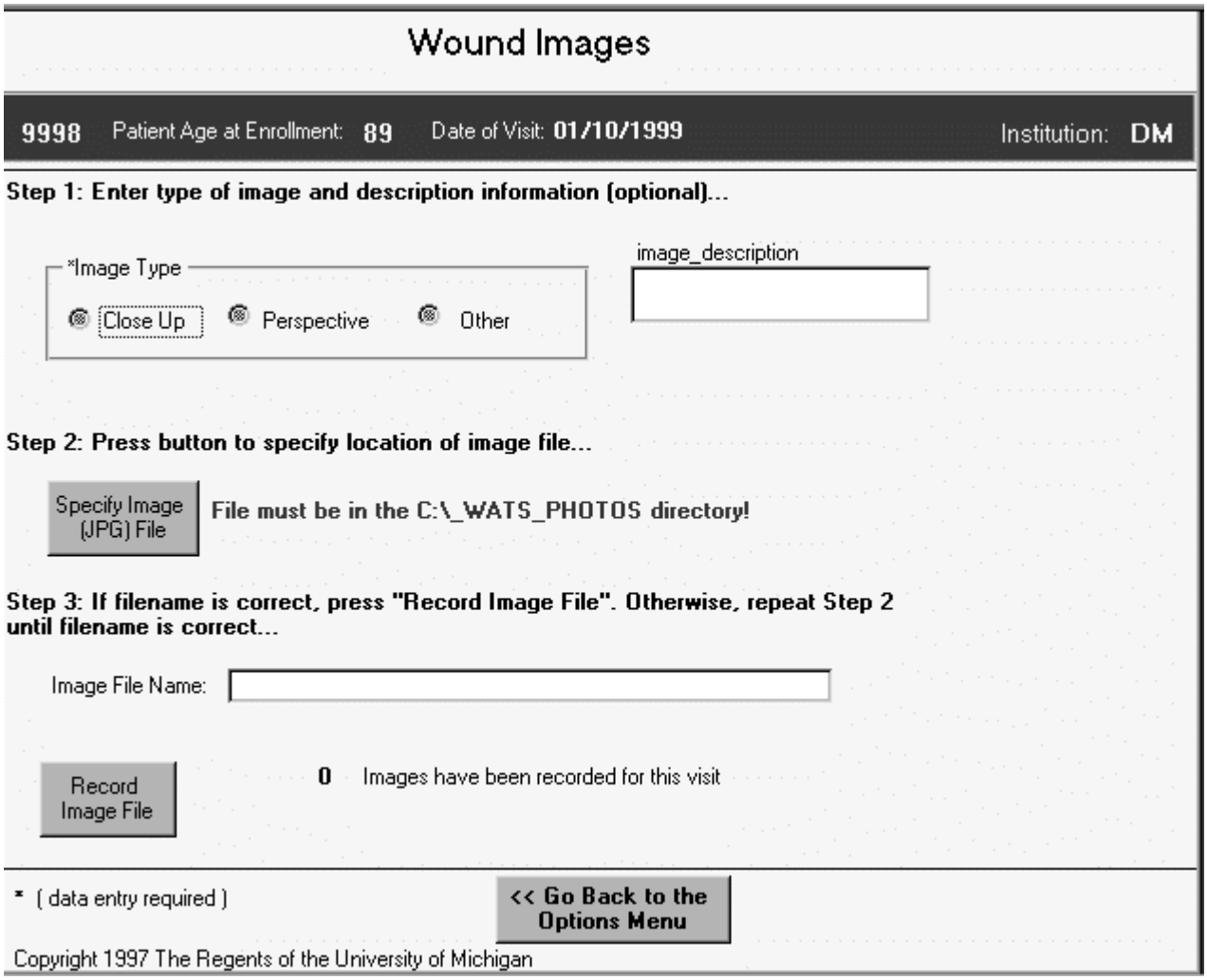
Details

Records in table_location_list are created with this form. Specifically, the following elements are entered:

Table_location_list

Location_code
Location_title

8 - WOUND IMAGES FORM



General

This form is used to record the filenames of the wound image files associated with the patient visit. You can enter as many image filenames as you have by repeating the process outlined on this form. You will take a minimum of two images of the wound for this study, as documented in the study protocol. After you have transferred the image files from the camera to your laptop, you are ready to complete this form. Your images must be stored in the c:_WATS_PHOTOS directory and uploaded to the Telemedicine Web site.

You must enter the image type and optionally, a description of the image. The description is particularly helpful for images classified as “Other”.

Click on the Specify Image File button to locate and select the filename where the image is stored on your laptop. When you have accurately listed the filename and path, click on the Record Image File button. This action will record the name of the image file associated with the active visit. A counter is shown to track the number of image filenames that are recorded for the visit.

When you have completed recording image filenames, click on <<Go Back to the Options Menu>> to return to the Options Menu Form. You do not have the option to edit this data once you have clicked on the “Record Image File” button. If you have not yet done so, you may cancel without saving the image information by not clicking the Record Image File button and returning to the Options Menu.

Description of Elements

Institution: This element is shown on every screen after you select it from the selection box on the Welcome screen.

Subject ID: This element is shown in every screen after you select it from the selection box on the Main Menu.

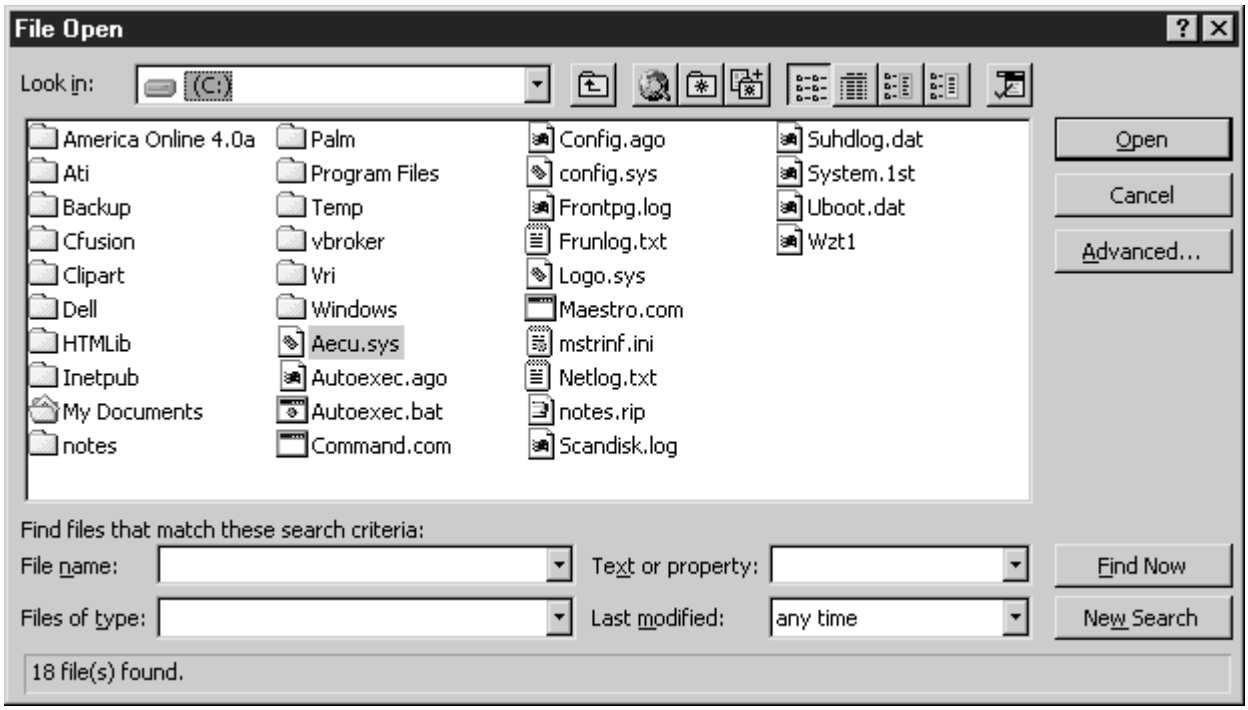
Age at Enrollment: This element is shown in every screen after you select the patient for which you are adding or modifying data.

Visit Date: This date is populated with the value for the current visit.

Wound Type: Specify Close Up, Fixed Distance, or Other by clicking on the associated radio button. Descriptions for each of these types is described in the study protocols.

Image Description: This is an open-text field in which you can enter clarifying information about the image. Use this field if you if the image to be saved is of type Other. You can use this field with any of the image types.

Specify Image File Button: Click on this button to specify the file where the image is stored on your laptop. A dialog box will appear that will allow you to click to the filename and select for saving as follows:



Required Elements

Image Type
Image File Name

Details

Records in table_wound_image are created with this form. Specifically, the following elements are entered:

Subject_id
Institution_id
Date_of_visit
Wound_number = 1
Image_number
Image_type
Image_description
imageOLE

9 - HEALTH AND NUTRITION FORM

General

This form has three parts, each in a separate tab: 1) Health History and Physical; 2) Nutrition History and Diet; and 3) Diagnoses. The following three sections describe each tab in turn. This section describes data elements and functions that are common to all tabs.

Subject ID, Patient Age at Enrollment, Evaluation Date, and Institution are shown in the heading. Evaluation date is populated with the date of last evaluation or the date of the record you wish to edit. This field is editable whether you are using this form to add new records or editing existing data. The Health and Nutrition Form contains hundreds of data elements through the three tabs. To ease data entry burden, the form is populated with information from the most recent prior evaluation. This allows you to edit information rather than having to repeat information that may not have changed since the last evaluation.

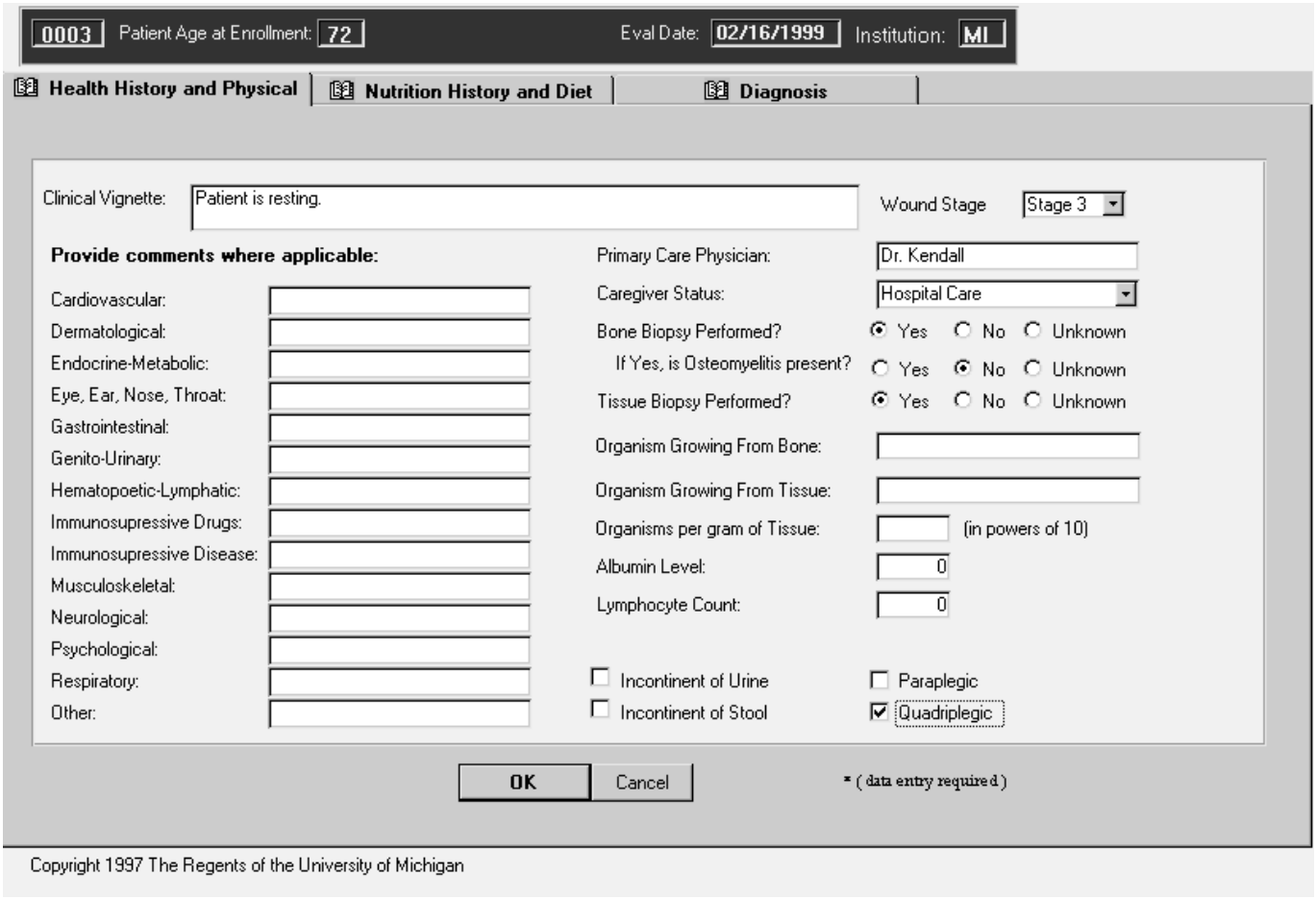
If you are in this form to edit existing data and more than one editable record exists, you will see navigation buttons on the bottom of the form. Use these buttons to click to the record you wish to edit or review:

Click OK to save changes and return to the Add/Edit Enrolled Patient Menu or Cancel to return to the menu without saving changes.

If you are entering this form to add new data, you will get the following message:

The message informs you that the form will be populated with data from the most recent health and nutrition record. You can edit any field for the new record. Click OK to continue.

9A - HEALTH AND NUTRITION FORM – HEALTH HISTORY AND PHYSICAL TAB



General

Elements on this tab are related to selected information commonly collected during a patient health history and physical.

Description of Elements

Clinical Vignette: This is an open text field in which to summary patient condition. This information will be made available to physicians to provide a quick sketch of the patient's overall condition.

Comments Where Applicable: Fourteen elements are listed for open-text comments ranging from Cardiovascular conditions to Other. Enter comments for conditions that apply to the patient. Leave the rest blank.

Wound Stage: Values for this element are Post Op, Stage 1, Stage 2, Stage 3, or Stage 4. Select the appropriate value from the list. If a wound type of Chronic was recorded for this patient in the Patient Enrollment Form, then choose Stage 1 – 4. Otherwise, choose Post Op. Under certain, circumstances, a patient with a wound type of Chronic may change to Post Op for a specific visit. This situation is highly unlikely, however.

Bone Exposure: Choose value from selection box. Available choices are Yes, No, and Unsure.

Primary Care Physician: Enter the name of the primary care physician.

Caregiver Status: Enter the nature of caregiving related to this patient. You have the option of entering an item not shown in the selection box.

Bone Biopsy Performed? Indicate whether or not a bone biopsy was performed by clicking on the appropriate radio button. If you are not certain, click Unknown.

Osteomyelitis Present? If a bone biopsy was performed, indicate whether osteomyelitis is present. If you are not certain, click Unknown.

Organism Growing from Tissue: Enter the type of organism growing from tissue based on lab results if known. If you do not have this information, leave blank.

Organism Growing from Bone: Enter the type of organism growing from bone based on lab results if known. If you do not have this information, leave blank.

Organisms per Gram of Tissue: Enter this value from lab results in power of 10, if known. If you do not have this information, leave blank.

Albumin Level: Enter the lab value here. If you do not have this information, leave blank.

Lymphocyte Count: Enter the lab value here. If you do not have this information, leave blank.

Incontinent of Urine: Check this box if this applies to the patient.

Incontinent of Stool: Check this box if this applies to the patient.

Paraplegic: Check this box if this applies to the patient.

Quadriplegic: Check this box if this applies to the patient.

Required Elements

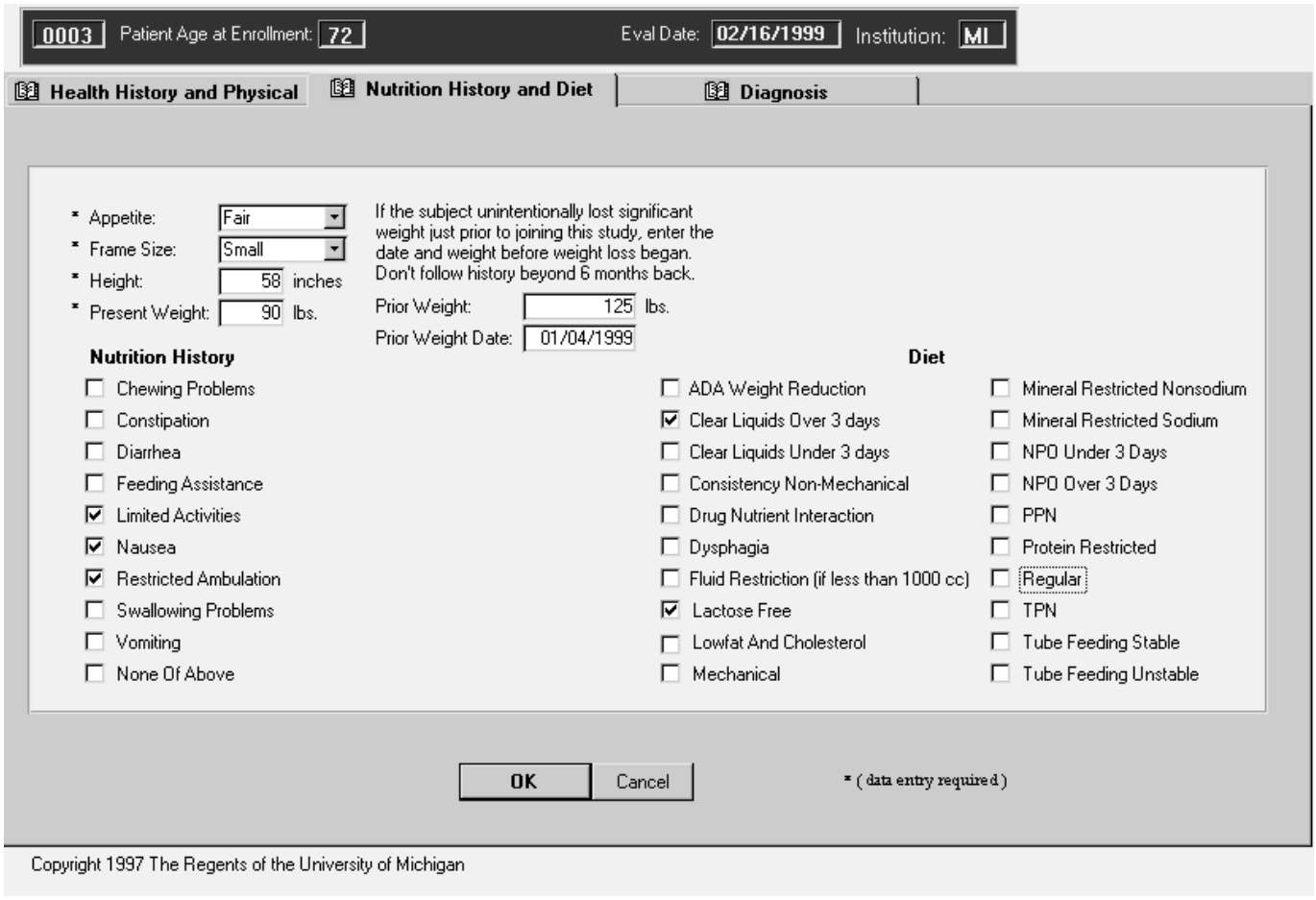
Primary Care Physician

Details

Records in table_patient_health are created or modified with the Patient History and Physical tab in the Health and Nutrition Form. Specifically, the following elements are entered:

Clinical_vignette
Cardiovascular
Dermatological
Endocrine_metabolic
Eye_ear_nose_throat
Gastrointestinal
Genito_urinary
Hematopoetic_lymphatic
Immunosupressive_drugs
Immunosupressive_disease
Musculoskeletal
Neurological
Psychological
Respiratory
Other
Primary_care_physician
Caregiver_status
Organism_growing_from_bone
Organism_growing_from_tissue
Organisms_per_gram
F_albumin_levelf
G_lymphocyte_count
Incontinent_urine
Incontinent_stool
Bone_biopsy
Osteomyelitis
Tissue_biopsy
Wound_stage

9B – Health and Nutrition Form – Nutrition History and Diet Tab



General

Elements on this tab are related to patient nutrition history and diet. These elements are used to compute general nutrition status of the patient, which is a key variable in the study.

Description of Elements

Appetite: Use the selection box to choose the appropriate level of appetite. Choices are good, fair, poor, or none.

Frame Size: Use the selection box to choose the appropriate frame size for the patient. Choices are small, medium, or large.

Height: Enter patient height in inches as an integer.

Present Weight: Enter patient weight in pounds as an integer.

Prior Weight: If the patient experience unintentional weight loss prior to the study enter the weight before this loss. Leave blank if this does not apply.

Prior Weight Date: Enter the date if the patient lost significant weight . Leave blank if this does not apply.

Nutrition History: You are queried on ten items. Check the box for each item that applies to the patient.

Diet: You are queried on twenty items. Check the box for each item that applies to the patient.

Required Elements

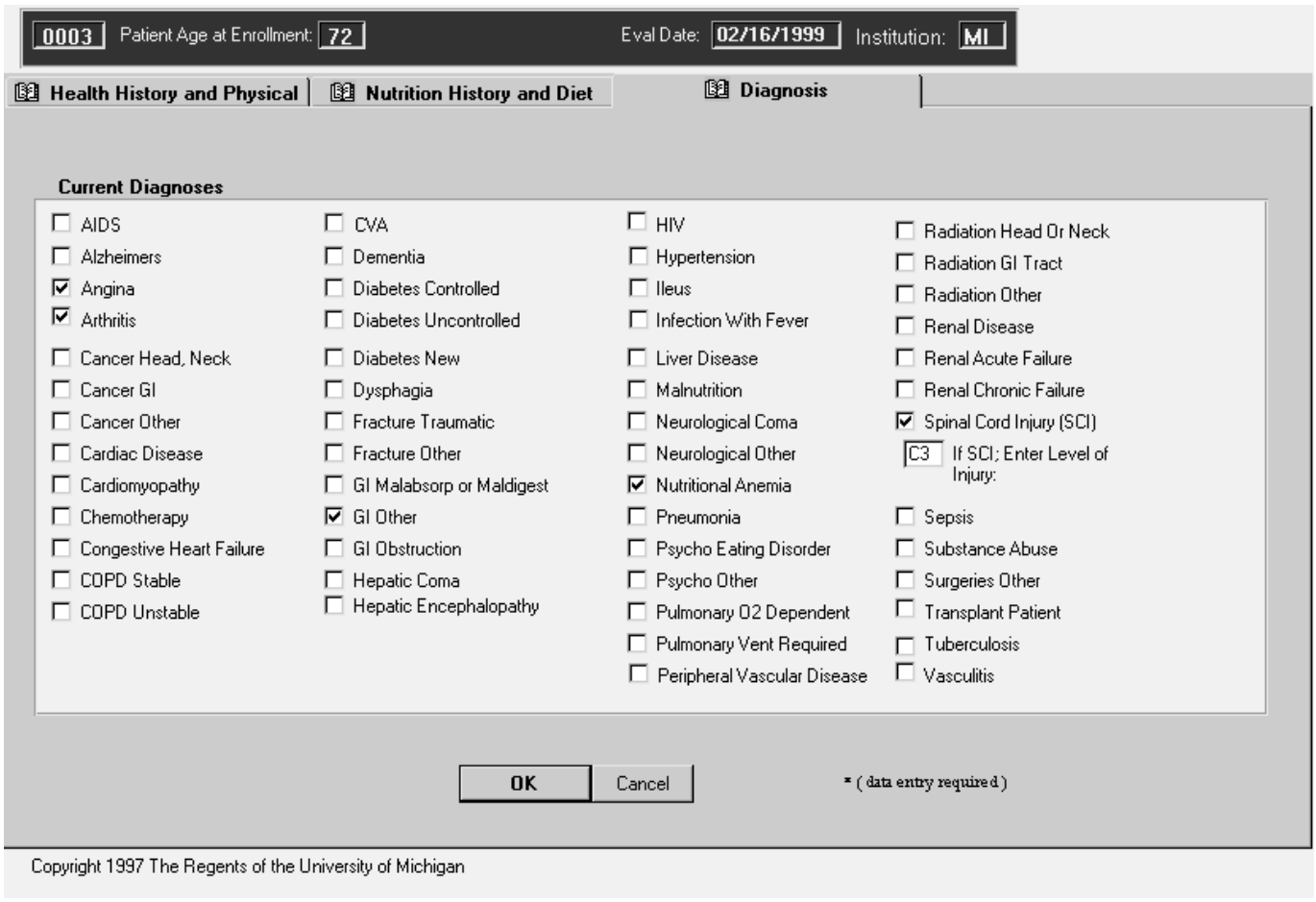
Appetite
Frame Size
Height
Current Weight

Details

Records in table_patient_health are created or modified with the Nutrition History and Diet tab in the Health and Nutrition Form. Specifically, the following elements are entered:

A_appetite
C_frame_size
C_height
B_present_weight
B_prior_weight
B_prior_weight_date
A_chewing_problems
A_constipation
A_diarrhea
A_feeding_assistance
A_limited_activities
A_nausea
A_restricted_ambulation
A_vomiting
A_none_of_above
D_ada_weight_reduction
D_clear_liquids_over_3days
D_clear_liquids_under_3days
D_consistency_non_mechanical
D_drug_nutrient_interaction
D_dysphagia
D_fluid_restriction
D_lactose_free
D_lowfat_and_cholesterol
D_mechanical
D_mineral_restricted_nonsodium
D_mineral_restricted_sodium
D_npo_under_3days
D_npo_over_3days
D_ppn
D_protein_restricted
D_regular
D_tpn
D_tube_feeding_stable
D_tube_feeding_unstable

9C - HEALTH AND NUTRITION FORM – DIAGNOSIS TAB



General

Elements on this tab are related to patient diagnosis. A series of 53 items are listed. Check all boxes that apply to the patient. An additional element is added to record the level of injury for spinal injury patients.

Description of Elements

Diagnosis Elements: Check all boxes that apply.

Level of Injury: For patients with spinal injury, indicate the location of injury e.g. C3.

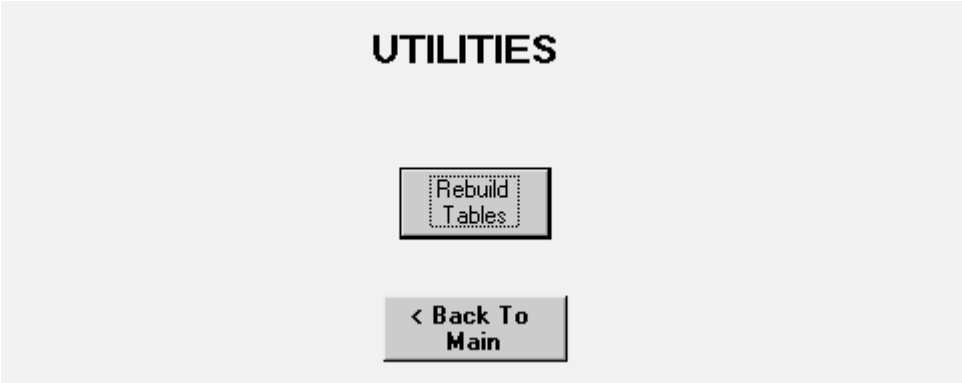
Required Elements

No required elements

Details

Records in table_patient_health are created or modified with the Diagnosis tab in the Health and Nutrition Form. Specifically, the following elements are entered:

E_aids
E_alzheimers
E_angina
E_arthritis
E_cancer_head_neck
E_cancer_gi
E_cancer_other
E_cardiac_disease
E_cardiomyopathy
E_chemotherapy
E_congestive_heart_failure
E_copd_stable
E_copd_unstable
E_cva
E_dementia
E_diabetes_controlled
E_diabetes_uncontrolled
E_diabetes_new
E_dysphagia
E_fracture_traumatic
E_fracture_other
E_gi_malabsorp_or_maldigest
E_gi_other
E_gi_obstruction
E_hepatic_coma
E_hepatic_encephalopathy
E_hiv
E_hypertension
E_ileus
E_infection_with_fever
E_liver_disease
E_malnutrition
E_neurological_coma
E_neurological_other
E_nutritional_anemia
E_pneumonia
E_psycho_eating_disorder
E_psycho_other
E_pulmonary_o2_dependent
E_pulmonary_vent_required
E_peripheral_vascular_disease
E_radiation_head_or_neck
E_radiation_gi_tract
E_radiation_other
E_renal_disease
E_renal_acute_failure
E_renal_chronic_failure
E_spinal_cord_injuyr
E_level_of_injury
E_sepsis
E_substance_abuse
E_surgeries_other
Transplant_patient
E_tuberculosis
Vasculitis



General

The Utilities Screen provides the capability to repopulate your data tables with patient data. This utility can be used to recover data after inadvertenly deleting records. Most likely, it will be used following a version update of the WATS Nurse data entry interface.

Description of Elements

Rebuild Table: selection of this task will start the process to repopulate key patient tables. Be sure you are connected to the network before beginning this task.

Back to Main: this button will return you to the main menu.

Required Elements

No required elements.

Details

The table_patient_baseline, table_wound_baseline, and table_patient_health tables are repopulated with the Rebuild Tables option.